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19 June 2010

Hitting the high notes

See all the action from the C+D Awards night page 24

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> FOR GPs TO SUGGEST THAT PHARMACISTS ARE UNSCRUPULOUS BUSINESS PEOPLE AND GPs ARE ABOVE SOMETHING AS DISTASTEFUL AS MONEY IS A LITTLE DISINGENUOUS

Collaborate. It's so often the word used to describe how pharmacists and GPs should navigate their tricky inter-professional relationship. It's interesting – or perhaps telling – then, that the historical meaning of the word is "to co-operate traitorously with an occupying enemy". Because it is abundantly clear over the following pages that both professions feel the other is encroaching on its territory.

I have heard GPs suggest that pharmacists can't be trusted because they make money from the products they sell. And in calling for full dispensing rights to combat what they perceive as a flood of service income away from general practice to community pharmacy (p6), local GP representatives pointedly referred to the latter as a "for profit" sector.

Am I missing something, or are GP practices not also businesses with financial targets? Do they not have prescribing budgets that could influence their decisions, and PCT directives that encourage them to swap one prescription for another based on cost?

Leaving aside the impact such directives have on the distribution of pharmacy funding, the motivation behind them is not necessarily all bad. Of course the NHS should get value for money from medicines. It's just that for GPs to suggest that pharmacists are unscrupulous business people and that they themselves are professionally above something as distasteful as money is a little disingenuous.

In this era of financial austerity it does all come down to money. As the latest C+D Senate concludes (p22), the two professions lack incentives to work together and feel they are playing tug-of-war over the same pot of cash. So the new government's commitment to GP-led commissioning is a big concern, as Dorset contractor Mike Hewitson points out (p14). Quite how the initiative will differ from its predecessor, practice-based commissioning, is far from clear. But there remains an awful lot of work to do to ensure community pharmacy is integrated into GP-led commissioning decisions.

A community pharmacy QOF aligned with the GP equivalent has been the much-mooted solution to these problems. C+D Senator and PSNC head of NHS services Alastair Buxton says this would be difficult (p22), but that doesn't mean we shouldn't try.

Community pharmacy's representative bodies clearly have a role to play in building the foundations for collaboration (or perhaps we should use the word co-operation). But as Mr Buxton also says, there is only so much national bodies can do before it comes down to individuals to build local links. So what are you waiting for?

Jennifer Richardson
Features Editor

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More coverage from last week's glittering ceremony

GPs demand full dispensing rights

Extended powers key to competing with new pharmacy openings, LMC conference hears

Jon Enoch

Who wants to dispense? GPs vote for dispensing rights at LMC conference

Max Gosney
max.gosney@ubm.com

GPs have demanded universal dispensing powers to help them compete with the "for profit" pharmacy sector.

Calls for deregulation brought landslide support at the Local Medical Committee (LMC) conference in London last week.

Doctors claimed service income was being drained by a glut of pharmacy openings under control of entry loopholes. Full dispensing rights would allow GPs to fight back on equal terms, delegates heard.

Ian Keith, of Hampshire & Isle of Wight LMC, said: "Deregulation and changes to the community pharmacy contract are seeing a one-way movement of NHS primary care to the for profit pharmacy sector."

Dr Keith proposed a motion urging the government to grant GPs full dispensing rights.

The move would increase competition in primary care and boost access for patients, he said.

Deregulation would also prove cost effective, with GP dispensing no more expensive than pharmacy dispensing, Dr Keith added.

LMC delegates approved the motion, which was one of seven tabled on dispensing.

Another voted in by the LMC urged greater protection for dispensing doctors against new pharmacy openings.

Richard Haddad, of Bradford & Airdale LMC, proposing, said: "I am a member of an endangered species, speaking for survival. For many surgeries, dispensing of medicines has been a service provided to patients when pharmacies wouldn't because it was not cost effective."

Control of entry was again under fire as Dr Haddad said practices had "suffered" under changes to pharmacy opening rules.

He urged colleagues to campaign for universal dispensing rights to protect the future viability of practices.

"We need the support of the GPC by removing restrictions, thus allowing all GPs to dispense medicines."

Both motions could now shape the General Practitioners Committee's (GPC) policy on dispensing and be raised in discussions with the Department of Health.

RPSGB targets 70 per cent member retention

The RPSGB has targeted retaining 70 per cent of its members when it becomes a voluntary professional leadership body (PLB), C+D can exclusively reveal.

The figure comes in a membership plan due to be presented at an English Pharmacy Board meeting on June 23.

The disclosure marks the first official acknowledgment from the RPSGB that it is basing its PLB plans on less than 100 per cent buy in.

"The membership retention target for the 2011 renewal is 70 per cent of RPSGB members at the point of split," stated a PowerPoint presentation due to be given at the meeting by Patrick Stubbs, RPSGB director of marketing and membership.

This equates to 34,144 members, according to the document seen by C+D.

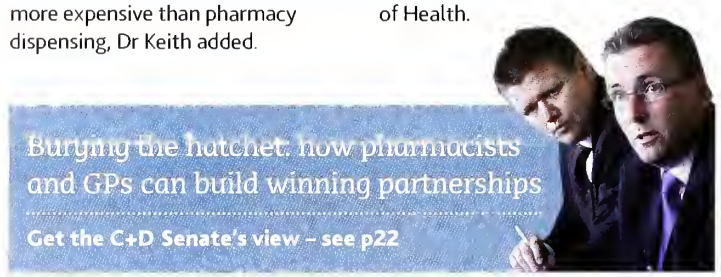
The presentation also details a membership engagement plan. The strategy includes "opportunities to share information and positive messages about the Society", a six-month maximise your membership campaign and a welcome pack.

Pharmacists signing up will be encouraged to make public declarations of their support.

A series of discount membership deals are also outlined in the document to ensure the new PLB is "commercially viable".

Retired pharmacists not in paid employment and women on maternity leave could get reduced rates under proposals.

Broader membership categories had been agreed by the Society but will be subject to a special resolution post de-merger. This is currently set for September. **MG**



White paper 'in limbo' as DH officials await go-ahead

The pharmacy white paper's future is unclear, with Department of Health officials still waiting for the new government to give the go-ahead to implement plans, C+D understands.

Speaking at last week's C+D Awards, NPA chairman Ian Facer described the 2008 white paper as being "consigned to the shredder by the change of government".

However, DH community pharmacy tsar Jonathan Mason told C+D: "Any white paper is the policy of the government of the day, so when the government changes it's sort of in limbo."

But he added that although the new government had not yet committed to the white paper as such: "In opposition both the Conservatives and the Liberal Democrats agreed with the principles of the white paper so it's not in the shredder."

Mr Mason said ongoing negotiations between PSNC and NHS Employers were continuing, but said policies such as a national minor ailments scheme would need sign off from the new government.

PSNC head of NHS services Alastair Buxton said work was continuing on "a number of action points" from the white paper. **ZS**

Supply deals bill on the way, wholesalers warn

Expect more delivery surcharges, BAPW conference told

Chris Chapman
chris.chapman@ubm.com

Contractors should brace themselves for a profit hit as the sector is forced to foot the bill for supply deals, the British Association of Pharmaceutical Wholesalers (BAPW) has warned.

The traditional wholesale model was "finished", with around 55 per cent of manufacturers now using exclusive supply deals, BAPW chairman David Cole told the wholesaler body's annual conference on Wednesday. However, the schemes cost up to eight times more than previous arrangements. And pharmacy could see products excluded from discount schemes and delivery surcharges to offset costs, Mr Cole predicted.

He said: "You must... appreciate the cost of distribution to the total supply chain of the new arrangements must be higher, and none of the costs have been exposed to the payer yet."

Mr Cole added: "I am sure the various contractor negotiating bodies are acutely aware of these points and should be urgently looking for a compensatory adjustment."

Mr Cole also highlighted the erosion of margins on higher priced, faster moving branded products, the possibility of generics prices increasing, and some products being excluded from discount schemes.

"However these factors manifest themselves, the challenge for the supply chain and negotiating bodies will be to pass the true costs to the payer," Mr Cole added.

"It is only when the medicines supply chain starts to cost more money for the government that we will see the market guidance that is so desperately needed now."

Stock shortages were also a "major concern" and had "dominated the work and thinking" of BAPW, Mr Cole said. Around 800 branded medicines had now been affected by the drugs drought, he said.

David Cole: new deals cost eight times more than previous arrangements

EU boss: shortages in UK 'exceptional'

The stock shortages situation in the UK is exceptional and would not be tolerated in other countries, the secretary-general of the Pharmaceutical Group of the European Union (PGEU) has suggested.

John Chave of the PGEU told C+D at the annual general meeting of the European Association of Pharmaceutical Full-Line Wholesalers (GIRP) in Cannes: "What's happening in the UK is exceptional." He said the level of direct to pharmacy deals was not being seen elsewhere, and added that if other countries were having comparable stock problems there would be "revolutions".

Mr Chave suggested it was "inevitable" that the UK would need to move towards more regulation to resolve the issues. **ZS**

For a full report from the GIRP AGM, see page 10

And the winner is: industry leaders, community pharmacists, manufacturers and more attended a glittering ceremony last week to honour the very best the sector has to offer at the C+D Awards 2010, in association with the NPA. Prizes were awarded for everything from pioneering clinical services to MUR champions, with the coveted Community Pharmacist of the Year title scooped by Taseen Iqbal of Modi Pharmacy, Dudley. For more photos from the night, see page 24. To find out who won the awards and watch interviews with the winners on the night, go to www.chemistanddruggist.co.uk/awards

In brief

GPhC considers clause

The future regulator has agreed to review the inclusion of the 'conscience clause' in its first year of operation. This follows a consultation on the revised draft standards that closed last month. The GPhC, which will take over as regulator in September, will propose the Council adopts the standards at a meeting this week. **www.chemistanddruggist.co.uk**

MBE for Martin Bennett

Martin Bennett, MD of Sheffield's Associated Chemists (Wicker), has been awarded an MBE in the Queen's Birthday Honours list for services to pharmacy. Mr Bennett praised his staff for helping him achieve the honour.

Howe on confidentiality

Pharmacy minister Earl Howe has emphasised the RPSGB Code of Ethics in ensuring patient confidentiality in a written statement to parliament. The response followed questions from Lord Mawhinney on the extent of guidance for pharmacists on protecting health information. **www.chemistanddruggist.co.uk**

GP campaigns under fire

The RPSGB has voiced concerns that the latest consultation into control of entry in Scotland was triggered by "unhelpful" dispensing GP campaigns. Lyndon Braddick, director for RPSGB Scotland, said the campaigns were based on the false premise that GP dispensing services would close if a pharmacy opened nearby.

HPCN first meeting

The Healthcare Professionals Commissioning Network (HPCN) has held its first meeting at the RPSGB. The session debated how pharmacists can engage in GP commissioning. See p14 for Mike Hewitson's verdict.

CIP payment checks

PSNC has reminded contractors that the deadline for requesting checks to their CIP payments for the period up to March 31, 2009 is June 30 this year. Information on requesting a check is available on www.nhsbsa.nhs.uk/PrescriptionServices/3057.aspx

Dispensary talk

Who would win the pharmacy World Cup?

"France would win because of their higher quality services including a lot of blood testing and cholesterol testing on site."
Kevin McDevitt, Crossin Chemist, Belfast

"I would have to say Italy because I am Italian! If I could though, I would say Scotland, as in Scotland we offer a service that is just a bit different from the one in England."
Lucia Castagnetti, The Co-operative Pharmacy, Fife

Web verdict

England 27%

France 20%

USA 20%

Denmark 33%

Armchair view: It appears we have as little faith in our pharmacies as we do in our football team as only 27 per cent of respondents felt England offered the best pharmacy services in the world.
Next week's question:
Could pharmacy compete with universal GP dispensing? Vote at **www.chemistanddruggist.co.uk**

Glasgow boasts record smoking cessation year

Pharmacies helped more than 5,000 patients to quit last year

Chris Chapman
chris.chapman@ubm.com

Pharmacists in Glasgow have reported a record year for the city's smoking cessation service, with more than 5,000 patients quitting through the scheme in 2009.

The 312 pharmacies participating in the city's Pharmacy Smokefree Service (PSFS) helped 5,016 patients to quit smoking last year, it was revealed at the UK National Smoking Cessation Conference on Monday.

Around 50 pharmacies had also participated in Greater Glasgow and Clyde Health Board's PSFS Plus scheme, which saw pharmacists offer 20-minute weekly counselling sessions and dual NRT therapy options for smokers. Despite being a more expensive intervention, the scheme had seen a higher quit rate and lower relapse rate than PSFS, resulting in a cost per quitter of around £2,000 – about £500 less than PSFS alone.

Glasgow pharmacies earned £45 for every patient who reached 12 weeks without relapse

However, PSFS had not proved a total success, after an initiative in which dentists referred patients to PSFS pharmacies failed after only one patient used the scheme. The scheme, which involved 29 dental surgeries and 28 pharmacies, saw dentists follow a basic advice and referral pathway, giving patients who were smokers a referral card asking them to see their pharmacist.

After 12 months only one patient had presented to a pharmacy after referral, despite most dentists reporting they had referred the majority of their smoking patients to local pharmacies.

Pharmacists providing PSFS in Glasgow were paid £45 per patient reaching 12 weeks without relapse, while PSFS Plus pharmacies were paid £65.

How successful is your quit smoking service?
chris.chapman@ubm.com

Clinical debate

C+D's Chris Chapman looks at the evidence behind the headlines

No arguments – just evidence

Last week, GPs gathered for their annual LMC pow-wow and called for pharmacists to only work to evidence-based standards. A second motion raised concerns about "unproven" and "unhelpful" treatments sold in pharmacies. Do the doctors have a point? I think they do, albeit one mired by a spot of gleeful pharmacist-bashing: we need to look at evidence bases, not just for medicines and services, but for all products sold in store.

Take homeopathy – it is, after all, Homeopathy Awareness Week (June 14 to 21). In February, the House of Commons Science and Technology Committee published its evidence check on the alternative therapy. The report was backed by multiple meta-analyses and could not have been more damning. It found there was no credible evidence of homeopathy's efficacy beyond placebo, and that its supposed mechanism was "scientifically implausible".

And yet pharmacists sell homeopathic products. Arguments used to defend these sales are the patient's right to choice, and their belief in the therapy delivering a valid result (ie the placebo effect).

Choice and belief are undeniably powerful factors, but as the RPSGB argues: "It is essential... the patient is given the appropriate information to make these informed choices and as a consequence it should be clear to the patient that there is no scientific evidence for homeopathy."

Concordance is all about working with the patient to deliver a health outcome. It's false choice if a patient isn't truly informed about their medicines. And if by informing the patient you lose all the medicine's effectiveness (by bursting the placebo effect bubble), what benefit does the treatment give?

Ignore the holier-than-thou hypocrisy of GPs (after all, they wrote the 19,000 prescriptions for homeopathic products that were dispensed last year in England alone). Instead, take the valid point that all health professionals need to use the best available evidence in all areas of practice. If something doesn't fit that criterion, we need to consider if it should be taking up shelf space.

- Links to all sources are available at **www.chemistanddruggist.co.uk/cpdzone**

To discuss this subject in private with your pharmacy colleagues, join the debate in C+D's LinkedIn group at www.linkedin.com – search for Chemist and Druggist.

Chat with Chris on Twitter: www.twitter.com/CandDChris

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NPA steps up CEO hunt

EXCLUSIVE Candidates need community pharmacy experience

Max Gosney
max.gosney@ubm.com

The NPA has officially launched the hunt for a new £130,000 a year chief executive.

Adverts for the post will run in the national press this weekend, with the organisation aiming to secure a successor to John Turk by late summer.

The next CEO does not have to be a pharmacist, the NPA said. However, the organisation will favour candidates familiar with community pharmacy, chairman Ian Facer told C+D.

"The way we are wording it is someone with experience of community pharmacy. They may well be a pharmacist, but are we specifically [selecting pharmacists]? The answer is no."

The application process will close in mid-July, Mr Facer added.

The NPA will not "jump at anybody" he stressed, adding that the organisation wanted a natural leader who could master the "complexities" of pharmacy.

The NPA lost its second chief executive in two years when John Turk quit the organisation this April.

The NPA had not attempted to headhunt successors from within the sector, Mr Facer said. However, the organisation will look to canvass industry leaders on recommended candidates for the post, he added.

A key goal for the next NPA CEO will be developing the organisation's representative role, Mr Facer said.

Hitting the road: former NPA boss John Turk has revealed how he took a 1,200-mile Australian road trip in the wake of his departure from the the association. Mr Turk journeyed from Melbourne to Brisbane on two Harley-Davidsons earlier this summer. He has now returned to the UK and hinted at a possible return to pharmacy. Mr Turk resigned from the NPA CEO post in April

In brief

Governance duty

DH officials have confirmed changes to the governance requirements to be met by community pharmacies by March 31, 2011. The changes will appear in version 8 of the online toolkit, scheduled for the end of June.
www.chemistanddruggist.co.uk

Telmisartan study

Boehringer Ingelheim has reacted strongly to a meta-analysis suggesting the angiotensin receptor blocker telmisartan treatment is associated with a small increase in new cancer diagnoses.
www.chemistanddruggist.co.uk

Yoghurt hayfever relief?

Researchers are studying whether yoghurt-type drinks can help bring relief to hayfever sufferers. A year-long study is being undertaken by a team from Norwich Research Park, led by allergist Dr Andrew Wilson.
www.chemistanddruggist.co.uk

100-hour pharmacy plans spark opposition

Plans for a 100-hour pharmacy in Islington have sparked local opposition, with more than 90 patients signing a petition that has been sent to the local PCT against the PharmacyRepublic application.

The local LPC has echoed residents' concerns. Members believed there was no need for another pharmacy in the area, said David Kent, secretary for Camden and Islington LPC.

"The LPC finds itself in an awkward position as once it opens [the LPC] has to support them," he told C+D.

PharmacyRepublic declined the opportunity to comment when approached by C+D.

NHS Islington said it was aware of local opposition to the application, adding it had little choice under guidelines to acknowledge this.A spokesperson said: "NHS Islington is very aware of local concerns and petitions around the need and desirability of new pharmacies opening in the local area, but under the regulations it is unable to take any of these issues into account."

Chandra Patel: fears 100-hour pharmacy could affect his business

Ulrika Dewhurst of Carters Chemist criticised the situation. She said: "There's no legislation and no one cares. It's not a question of supply as there are two pharmacies nearby."

Chandra Patel, co-owner of Caledonian Pharmacy, said he feared a loss of prescription business under the plans. He said: "Some of my customers are worried about [the plans], and I am against it because I think it will affect my business." **HF**

Are you ready for the hayfever season?

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Stock shortages – is it time to look to Europe for solutions?

As UK stock problems continue, other European countries seem to have solved the shortages problem. **Zoe Smeaton** finds out how at the annual general meeting of the European Association of Pharmaceutical Full-Line Wholesalers (GIRP)

The UK stock shortages situation is "exceptional", says John Chave, secretary-general of the Pharmaceutical Group of the European Union (PGEU).

In most other countries patients are not being forced to wait several days for their medicines and pharmacists are not juggling manufacturer and wholesale orders trying to secure stock.

Most experts agree the situation in the UK is due to a combination of manufacturer quotas and medicines being exported as the weak value of the pound makes the practice profitable. While the UK currency situation is unusual, European neighbours have grappled with quotas and other stock issues and coped, perhaps better than this.

In the UK, PSNC chief executive Sue Sharpe says supply chain stakeholders do have a duty to ensure patient needs are met, for example by not exporting medicines where there are shortages. In reality this has not been enforced strongly though, and one conclusion of the supply chain summit hosted by ministers in March was that the MHRA would begin targeted inspections of those suspected of breaking the rules.

This is a step in the right direction, but other European governments such as Germany and France have gone further and placed an additional public service obligation on full-line wholesalers to ensure the supply of medicines to patients. Martin Sawer, executive director of the British Association of Pharmaceutical Wholesalers (BAPW), explains that such a requirement means manufacturers are also then required to ensure continued supply.

The GIRP annual general meeting heard that France had become a model and a pioneer in wholesale distribution. Full-line wholesalers there have a public service obligation to meet orders within 24 hours and must hold enough stock to meet usual demand for two weeks. The meeting heard strong regulation was also in place to ensure stakeholders were compliant with the guidelines.

And perhaps these tactics could help. Although Mr Sawer says he can't be sure they would work in the UK, he adds that the association is "very much interested in these ideas". The solution could even appeal to manufacturers, he says, as it would remove the need for them to make emergency supplies directly to pharmacies.

"Manufacturers don't really want to deliver directly but at the moment that is the only way they can demonstrate that a particular drug is going to a particular patient," he says.

Jeremy Main, managing director at Alliance Healthcare, agrees looking to such European solutions could be helpful. He says working with the BAPW, the group has "observed a number of steps taken by the industry and governments, such as systems being put in place to closely monitor parallel trade and manufacturers being eventually convinced to put more stock into the supply chain".

If the situation is to change though, there needs to be pressure on the government to adopt these solutions. Mr Chave says he suspects other European countries would not have put up with the problems for as long as the UK has. And as Mr Sawer suggests, either a national patient voice is needed, or perhaps it will all boil down to "whether pharmacists are prepared to put up with this complication" for much longer.

Do you have a solution to the supply chain woes?

zoe.smeaton@ubm.com

The experts' views

"We welcome the commitment from the MHRA to undertake a programme of inspection. Those who breach existing duties to supply medicines must face the consequences."
Sue Sharpe, chief executive, PSNC

"Good progress has been made in the UK but there is still more that can be done to address stock shortages. We agree with the idea of looking at the approaches of other European countries."
Jeremy Main, managing director, Alliance Healthcare

"It is the government's responsibility to maintain the supply of medicines. The new government is committed to looking at the the supply chain."
Jonathan Mason, national clinical director, primary care and community pharmacy, DH

"We look forward to a speedy resolution."
Neal Patel, head of corporate communications, RPSGB

Seven-figure spend to market Shape Smart

Goldshield Healthcare has announced a seven-figure marketing campaign for its weight loss range Shape Smart.

Starting on June 21, the campaign will feature celebrities and is aimed at driving footfall into pharmacy, according to the company.

A free online assessment tool, available at www.eatertypes.co.uk, is designed to enable consumers to find out what "Eater Type" they are.

The campaign follows the launch of DEcarb earlier this year, aimed at people who consume excess carbohydrates.

Prices and Pip codes: **See C+D Monthly Price List or visit www.cddata.co.uk.**
Ceuta Healthcare
Tel: 01202 780558
www.decarb.co.uk

Market focus

- Sales of diet shakes, food bars, slimming supplements and meal replacements have risen by a third in the last two years (mysupermarket.co.uk, May 2010).
- The slimming market is worth £66 million a year (Nielsen, May 2010).

Radiotherapy aftercare in pharmacies

Water-Jel Technologies has announced the launch of a new treatment for radiotherapy patients.

R1&R2 is a two-step treatment to prevent and treat the effect of radiotherapy on patients' skin.

Both cooling gels in the treatment contain the milk protein fluid Lactokine, building skin protection, promoting healing and reducing irritation.

One is applied soon after therapy and the other is applied several times daily by the patient at home, according to the company.

The product is available in unit dose sachets.

Prices and Pip codes: **See C+D Monthly Price List or visit www.cddata.co.uk.**
Water-Jel Technologies
Tel: 01992 583222
treatmentinfo@waterjel.net

GSK launches Aquafresh mouthwash brand

GSK Consumer Healthcare has announced the launch of an Aquafresh range of mouthwashes and the relaunch of Aquafresh Extreme Clean Purifying Mouthwash.

The new range, Aquafresh Extra Care, is available in three flavours – tingling mint, spearmint and mint breeze.

The company says it plans to attract new users to the mouthwash category with the range, which is suitable for children aged six years to adults.

Aquafresh Extra Care will be supported with a £2.1 million media support package this year.

Prices: **£2.99/ 500ml (Extra Care); £3.29/500ml (Extreme Clean)**
Pip codes: **355-6784 (mint breeze), 355-6768 (tingling mint), 355-6776 (spearmint); 355-6792 (Extreme Clean)**
GSK Consumer Healthcare
Tel: 0845 762 6637
www.mypharmassist.co.uk

£1.2 million campaign for Savlon range

Savlon will be the focus of a £1.2 million television campaign, Novartis has announced.

The campaign started this week and will continue throughout July and August; instore promotional activity will also continue throughout 2010.

The strap line "Savvy Mums use Savlon" will be used in the advert, which aims to demonstrate the full range of Savlon products available to treat children.

The campaign will highlight recent additions to the range, including spray plaster and antibacterial hand gel.

Prices: **From £1.31**
Pip codes: **See C+D Monthly Price List or visit www.cddata.co.uk**
Novartis Consumer Health
Tel: 01403 218111
www.savlon.co.uk

Check out what's on TV this week, online at www.chemistanddruggist.co.uk/prodnews

Challenging times on the high street

"NOT A DAY GOES BY WITHOUT BEING OFFERED YET ANOTHER PIECEMEAL ADD-ON TO MY SERVICES"

Ever played Twenty Questions? You know, the game that goes "Does it sell shampoo, make-up, and rubber gloves?" Yes. "Is it a beauty salon or a hardware store?" No. "Direct you to the nearest dentist or hospital?" Yes. "Is it a library?" No. "Check your blood pressure and glucose levels?" Yes. "Is it a doctors' surgery?" No. "Can you get pregnancy tests and contraception?" Yes. "Is it a Family Planning Clinic?" No. "I give up – I don't know what it is." Neither do I – and I work here..!

Last week I mentioned the shop or clinic conundrum, and this will become an ever greater issue for pharmacy. People keep talking of a variable contract: prescription factories paid a small fee but making money from buying margins, and pharmacies that specialise in clinical services receiving greater income from fees. But that will marginalise the traditional pharmacy that simply dispenses and sells beauty products and cosmetics. Ever more Pharmacy medicines moving to GSL, the latest likely to be Regaine, removes reasons for people to come through the door – and even when they do, the price competition from supermarkets and internet pharmacies has slashed traditional margins. They say "The high street landscape is changing", and we're starting to realise it's our high street.

I have never wanted to be a shopkeeper, so I should welcome the move on from when patient counselling meant dispensing the right tablets, explaining what they do and how to take them, and telling the patient not to drink with them. And if you smiled while you did all that, you were giving good service.

Today, a technician dispenses the right tablets, while I'm doing an MUR to explain what they do and how to take them, assessing the patient's CHD risk, and giving a Nice brief intervention not to drink alcohol at all! Meanwhile the PCT paperwork that goes with each little LES claim means I haven't got time to smile.

And not a day goes by without being offered yet another piecemeal add-on to my services, the latest being Pfizer's vascular screen, which joins this new industry that sells screening services to pharmacies including testing hypertension, glucose, cholesterol, and – my favourite of all time – the NPA-promoted genetic paternity test! I did suggest the latter to the PCT as an add-on to our EHC LES, but with no success.

So where does that leave us? These times of change are also days of rumour, of pharmacies moving into surgeries and health centres, or swapping the personal care aisle for a suite of consultation rooms, which means it's a brave company that bets on which service model will prove viable.

Companies have got stung before – you're never too big to fail – so it's not only the independents who face uncertainty. Whatever the landscape of pharmacy services in 10 years, it will be an ever more challenging game to play.

Watch out for 'practice-biased' commissioning

The new government recognises the current system of healthcare commissioning is broken – it implies as much in its coalition document. The plan to overhaul it is, however, worrying. GP-led commissioning is to be the successor to practice-based commissioning, or "practice-biased commissioning", according to one colleague.

A white paper is imminent, which will tell us if the new route is to be a wunderkind or another enfant terrible. In an effort to shape the process before it has been crystallised in policy and law, I, along with other pharmacists and colleagues from dentistry, nursing, allied healthcare professionals and the PBC tsar James Kingsland, met to discuss what changes to the commissioning process were needed to improve NHS services and ultimately outcomes for patients.

Among the Healthcare Professionals Commissioning Network there was a genuine desire from everyone to open up the commissioning process to different providers, and a definite consensus that GP commissioning must not be GPs commissioning themselves exclusively to provide services. There was also a recognition that no single provider has the 'Heineken effect', ie can reach the patients that no other provider can reach.

We want to see teamwork in primary care, which at its most fundamental could see all primary care contracts (medicine, pharmacy, dentistry and optometry) redesigned to provide synergy and collaborative benefits at their core. This is potentially a radical shift that blurs professional boundaries, but it is in the best interests of the country to have a truly modern primary care service that utilises the skills and expertise of all its professionals, for the best value.

So how could this be achieved? My personal preference is for a form of quality and outcomes framework for pharmacy that focuses on public health (prevention and screening) and ensuring patients are able to get the best from their prescribed treatments.

If we can sharpen our efforts into quality communications with general practice (rather than overwhelming them with irrelevant paperwork), then we have the potential to really add value to a patient's journey through primary care, and help them avoid the evil clutches of secondary care. For this to work, every pharmacist will need to be single-minded in their delivery of healthcare, whether they be two years from retirement or newly registered.

We cannot afford to be seen as shopkeepers with a certificate any longer. After the emergency budget, I sense we will be able to afford it even less – at a time when community pharmacy needs investment more than ever.

Mike Hewitson, owner, Beaminster Pharmacy, Dorset

"GP COMMISSIONING MUST NOT BE GPs COMMISSIONING THEMSELVES EXCLUSIVELY TO PROVIDE SERVICES"

AN ANNOUNCEMENT FROM ALLEN & HANBURYS

In January 2009 Allen & Hanburys launched Avamys®▼ (fluticasone furoate), an intra-nasal steroid (INS) for treatment of the symptoms of allergic rhinitis.[1] Avamys (fluticasone furoate) is a different chemical entity to Flixonase® (fluticasone propionate) and is therefore a distinct drug molecule and not a salt or a prodrug of fluticasone propionate.[2]

A survey taken in May 2009, amongst 128 pharmacists showed that:[3]

- 31% were unaware of this INS (Avamys, fluticasone furoate).
- 63% were not aware of the differences between fluticasone furoate and fluticasone propionate.

Allen & Hanburys would like to highlight the important key differences that will support you in dispensing the right medicine.

	fluticasone furoate[1,4]	fluticasone propionate[4,5]
Dose per spray	27.5mcg	50mcg
Sprays per pack	120	150
Licence Age	6 years and older	4 years and older
Cost (on prescription)	£6.44	£11.01

In a single dose study comparing Avamys to fluticasone propionate nasal spray, patients preferred Avamys over fluticasone propionate based on sensory attributes.[6] Avamys provides relief from both nasal and ocular symptoms in an advanced device.[7-10] Avamys is available to purchase from AAH and Alliance Healthcare.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing)

Avamys®▼ Nasal Spray Suspension
(fluticasone furoate 27.5 micrograms/metered spray)
Uses: Treatment of symptoms of allergic rhinitis in adults and children aged 6 years and over. **Dosage and Administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily (total daily dose, 110 micrograms). Once symptoms controlled, use maintenance dose of one spray per nostril once daily (total daily dose, 55 micrograms). Reduce to lowest dose at which effective control of symptoms is maintained. *Children aged 6 to 11 years:* One spray per nostril once daily (total daily dose, 55 micrograms). If patient is not adequately responding, increase daily dose to 110 micrograms (two sprays per nostril, once daily) and reduce back down to 55 microgram daily dose once control is achieved. **Contraindication:** Hypersensitivity to active substance or excipients. **Side Effects:** Systemic effects of nasal corticosteroids may occur, particularly when prescribed at high doses for prolonged periods. *Very common:* epistaxis. Epistaxis was generally mild to moderate, with incidences in adults and adolescents higher in longer-term use (more than 6 weeks). *Common:* nasal ulceration. *Rare:* hypersensitivity reactions including anaphylaxis, angioedema, rash, and urticaria. **Precautions:** Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Caution when prescribing concurrently with other corticosteroids. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. Consider referring to a paediatric specialist. May cause irritation of the nasal mucosa. Caution when treating patients with severe liver disease, systemic exposure likely to be increased. Nasal and inhaled corticosteroids may result in the development of glaucoma and/or cataracts. Close monitoring is warranted in patients with a change in vision or with a history of increased intraocular pressure, glaucoma and/or cataracts. **Pregnancy and Lactation:** No adequate data available. Recommended nasal doses result in minimal systemic exposure. It is unknown if fluticasone furoate nasal spray is excreted in breast milk. Only use if the expected benefits to the mother outweigh the possible risks to the foetus or child. **Drug interactions:** Caution is recommended when co-administering with inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole and ritonavir. **Presentation and Basic NHS cost:** Avamys Nasal Spray Suspension: 120 sprays: £6.44 **Marketing Authorisation Number:** EU/1/07/434/003. **Legal category:** POM. **PL holder:** Glaxo Group Ltd, Greenford, Middlesex, UB6 0NN, United Kingdom. **Last date of revision:** January 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

Avamys is a registered trademark of the GlaxoSmithKline group of companies.

Prescribing Information
(Please refer to the full Summary of Product Characteristics before prescribing.)

Flixonase® Aqueous Nasal Spray
(fluticasone propionate 50 micrograms/metered spray)
Uses: Prophylaxis and treatment of seasonal allergic and perennial rhinitis in adults and children aged 4 years and over. **Dosage and administration:** For intranasal use only. *Adults:* Two sprays per nostril once daily in the morning. Once symptoms controlled, use maintenance dose of one spray per nostril once daily. Two sprays per nostril twice daily may be required. Maximum daily dose four sprays per nostril. *Children aged 4 to 11 years:* One spray per nostril once daily in the morning. One spray per nostril twice daily may be required. Maximum daily dose two sprays per nostril. For full therapeutic benefit regular usage is essential. The minimum dose should be used at which effective control of symptoms is maintained. **Contra-indication:** Hypersensitivity to any of its ingredients. **Precautions:** Local infections should be appropriately treated. Caution when transferring patients from systemic steroids. Systemic effects of nasal corticosteroids may occur at high doses for prolonged periods. Growth retardation has been reported in children receiving some nasal corticosteroids at licensed doses. Monitor height of children. In addition, consider referring patients to a paediatric specialist. Treatment with higher than recommended doses of nasal corticosteroids may result in clinically significant adrenal suppression. Consider additional systemic corticosteroid cover during periods of stress or elective surgery. Avoid concomitant administration of inhibitors of the cytochrome P450 3A4 system, e.g. ketoconazole, and ritonavir. **Pregnancy and lactation:** Clinical data is not available. Balance risks against benefits. **Side effects:** Very common: Epistaxis. Common: Headache, unpleasant taste, unpleasant smell, nasal dryness, nasal irritation, throat dryness, throat irritation. Very rare: Cutaneous hypersensitivity reactions, angioedema, bronchospasm, anaphylactic reactions, glaucoma, raised intraocular pressure, cataract, nasal septal perforation. **Presentation and Basic NHS cost:** *Flixonase Aqueous Nasal Spray:* 150 metered sprays - £11.01. **Market Authorisation Number:** PL 10949/0036 **Market Authorisation Holder:** Glaxo Wellcome UK Limited trading as Allen & Hanburys, Stockley Park West, Middlesex, UB11 1BT. **Legal category:** POM. **Date of preparation:** January 2010.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.gov.uk. Adverse events should also be reported to GlaxoSmithKline on 0800 221 441.

Flixonase is a registered trademark of the GlaxoSmithKline group of companies.

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GlaxoSmithKline

For more information on Avamys visit www.eyesandnoses.co.uk

Date of Preparation: May 2010 UK/FF/0070/10

ALLEN & HANBURYS
The specialist respiratory division of GlaxoSmithKline

Update

CPD revision guide

Module 153

Therapeutic drug monitoring: pt 2

The second of three articles on therapeutic drug monitoring concentrates on drugs used in epilepsy, bipolar disorder and chronic heart failure

Ravina Tasgaonkar MRPharmS

Therapeutic drug monitoring (TDM) is the close monitoring of drug concentrations in blood to avoid harm from high concentrations and inefficacy from low concentrations (see C+D, May 15, p16). This article describes how TDM can be used to ensure patients receive optimum benefit from anti-epileptic agents, antipsychotics and cardiac glycosides.

Epilepsy

Epilepsy is the most common serious neurological condition in the UK, with at least 300,000 people being treated. Patients have a two-to three-fold greater risk of premature death. Sudden unexpected death in epilepsy (SUDEP) is the main cause of seizure-related death, and is estimated to account for about 500 deaths each year. Young adults are most at risk, with most deaths occurring at home.

Up to 70 per cent of people with epilepsy have the potential to be seizure-free. However, in 1999 an audit of epilepsy-related death found that just under half of patients with epilepsy diagnosed in the five years before death were initially referred to a neurologist.[1] Many of the estimated 500 deaths could have been avoided with specialist intervention. It is now recommended all people with a recent onset suspected seizure should be seen urgently by a specialist to ensure precise diagnosis and early initiation of therapy with annual reviews.[2]

Anti-epileptic drugs (AEDs) are the mainstay of management. TDM often starts when initiating therapy, changing or using more than one AED.

Phenytoin

Phenytoin is mainly used for the treatment and prevention of seizures. It is administered orally or intravenously (IV), with the various forms having different bioequivalence. The clinically effective plasma level range is 10-20mg/l of blood (40-80 micromoles/l). It can take seven to 10 days to achieve steady state, and dose changes should not be carried out at shorter intervals.

Phenytoin is highly protein bound and metabolised by the liver. In patients with impaired liver function, the elderly or the gravely ill, protein binding can be reduced because of poor quality or inadequate amounts of protein production. It is important to reduce the dose in these patients to prevent 'free' phenytoin (the active fraction) levels rising, causing accumulation and toxicity.

Side effects increase in high doses and can affect patients' lifestyles. Serum levels above the optimal range may lead to delirium, psychosis, encephalopathy or – rarely – irreversible cerebellar dysfunction. Phenytoin is associated with a small increased risk of suicide so patients should be assessed for this. Nausea, vomiting and constipation, weight gain, coarsening of the facial features, enlargement of the lips, gingival hyperplasia, hirsutism and hypertrichosis can be troublesome in young adults, and may cause patients to stop therapy abruptly. Abrupt withdrawal can result in status epilepticus.

Other adverse effects include skin rash, disturbed glucose metabolism and inhibited insulin release. Phenytoin, like other AEDs, can interfere with vitamin D metabolism,[3] and long-term use decreases bone density by an unknown mechanism, causing up to a six-fold increase in fracture risk. Osteo-protective behaviour should be encouraged, such as exposure to sunlight, adequate dietary calcium and vitamin D, and light-impact weight-bearing exercise.

Patients should avoid smoking, excessive alcohol intake (acute alcohol intake may increase phenytoin serum levels, while chronic alcoholism may decrease serum levels), non-essential bone-depleting medicines and enzyme-inducing drugs, as these can alter AED plasma levels. Bone mineral density should be assessed individually, taking risk factors for bone loss into account. Patients who have developed bone loss should be given specific anti-osteoporotic treatment.[4]

Common medicines that increase phenytoin levels include amiodarone, antifungal agents, diazepam, diltiazem, fluoxetine, H_2-antagonists, nifedipine and omeprazole. Common medicines that decrease phenytoin levels include folic acid, rifampicin, theophylline and St John's wort. Medicines that either increase or decrease phenytoin serum levels include carbamazepine, phenobarbital, sodium valproate, antineoplastics and ciprofloxacin.

Bipolar disorder

In bipolar disorder, patients have severe mood swings, usually lasting several weeks or months. These range from low or 'depressive' feelings of intense depression and despair to high or 'manic' feelings of extreme happiness and euphoria. Patients also experience mixed feelings of depressed mood with the restlessness and over-activity of a manic episode.

About one in every 100 adults has bipolar disorder at some point in their life. It is unusual to start after the age of 40.[5]

Stockcheck

Dispensary stock management course

This course has been accredited by the Royal Pharmaceutical Society of Great Britain

C+D Training

Stockcheck is a dispensary stock management course for pharmacy staff who process dispensary stock orders.

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- **Different types of medicines**
- **Ordering and reordering stock**
- **Receiving stock**
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Stockcheck has been accredited by the Royal Pharmaceutical Society of Great Britain and fulfils the RPSGB's condition that anyone working in the dispensary of a registered pharmacy must have completed or be undertaking an appropriate training programme within three months of starting work.

Course contributors

Stockcheck has been written and reviewed by a team of experienced pharmacists and medical writers in all four UK home countries. This ensures that the course content is up to date and relevant for pharmacy staff working in Scotland and Northern Ireland as well as England and Wales.

Course Materials

Students who register for the Stockcheck dispensary stock management course will receive a Workbook, which contains information to read and a series of activities and exercises for the student to work through.

Supervising pharmacists will receive a Supervisors Handbook to help them support their students while they are studying Stockcheck.

Assessment

Stockcheck is assessed via a set of multiple choice questions. The answers to these questions are marked using a telephone marking system.

Students are also required to submit their completed Workbook for marking. The Workbook must be marked by the student's supervising pharmacist before being submitted to C+D for external assessment.

Students will be certificated once they have passed the multiple choice questions and their Workbook has been passed as satisfactory by both their supervising pharmacist and the external assessor.

Support

All Stockcheck students and their supervising pharmacists have email and telephone access to a course administrator and a team of pharmacists, Monday to Friday 9am to 6pm.

C+D offers a range of email newsletters that will help students in their studies. Students can register for these at **www.chemistanddruggist.co.uk/register** The C+D website also contains a wide range of articles and features that will help students.

Cost

The cost of the Stockcheck dispensary stock management course is £47.00 (including VAT) for each individual student. This cost covers course materials, assessment and certification.

Register your staff today by completing the form overleaf.

To order course materials (comprising a Student Workbook and Supervisor Handbook) and register students for the Stockcheck Dispensary Stock Management course please complete the application form below and send it either:

1. With a cheque, made payable to UBM Information, or
2. With your credit/debit card details

Orders and registrations can also be taken with a credit/debit card over the phone – call 0207 921 8425.

Please note that course materials are issued on a per student basis and may not be shared. The cost of the course covers all materials and assessments.

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C+D Pharmacy Training, UBM Medica, 8th Floor, Ludgate House, 245 Blackfriars Road, London SE1 9UY

Our New Arrival

Dendron would like to welcome a new addition to the family – Snufflebabe!

Look out for Snufflebabe children's vapour rub, **now back in stock.**

For more information, contact your Dendron rep or call: 01923 205704

Snufflebabe trade mark and product license are held by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD18 7JJ.
Snufflebabe is a topical ointment to relieve nasal congestion (a blocked nose). Legal category: GSL. Further information available from DDD Ltd at the above address.

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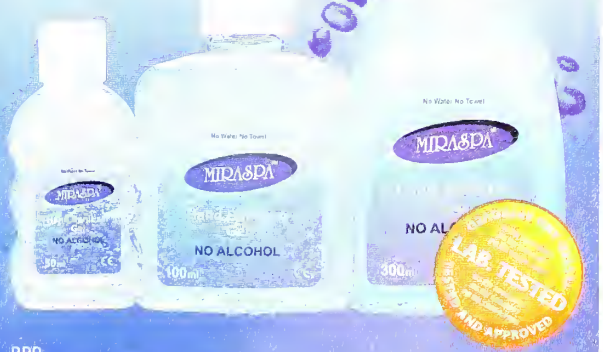

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Lithium

Lithium is mainly used in the management of acute manic or hypomanic episodes and as prophylaxis against bipolar affective disorders.

Lithium modifies the production and turnover of certain neurotransmitters, particularly serotonin, and may block dopamine receptors. Lithium is a monovalent cation and can behave similarly to sodium.[6]

The half life is about 24 hours, although this increases to about 36 hours in the elderly because of renal dysfunction. It is 95 per cent eliminated in the urine. The time to peak serum level for prolonged release Priadel tablets is two hours, with 90 per cent bioavailability.

Pre-treatment tests should include blood, urea, serum creatinine (used to calculate renal clearance), tri-iodothyronine (T3), thyroxine (T4) and thyroid stimulating hormone (TSH), full blood count and electrolytes, especially calcium. If TSH levels are raised, thyroid replacement should be started. These data can form the basis for comparison after treatment is initiated. If there is a history of cardiac dysfunction, patients should have an ECG on starting treatment, which is repeated annually.

The target lithium serum level is 0.4-1.0 mmol/l. A lower range may be suitable for the elderly or those with complicating factors. Different formulations deliver diverse bioequivalence so it is vital to stick to one brand, and any change in brand should be considered as initiation of new treatment. Steady state is achieved five to seven days after initiation. Plasma level monitoring should be done every three months if the patient is stable or more often if needed.

Signs of toxicity include marked tremor, ataxia and nystagmus, which should be investigated. Contraindications include cardiac disease, significant renal impairment, untreated hypothyroidism, breastfeeding, patients with low body sodium levels (eg dehydrated patients or those on low sodium diets) and Addison's disease.

Lithium can interact with other medications such as steroids, metronidazole, ACE inhibitors and non-steroidal anti-inflammatory drugs (NSAIDs), which increase lithium levels causing toxicity. Theophylline, caffeine, sodium bicarbonate and diuretics decrease serum lithium concentrations. There are more interactions with neurological medicines. Nausea, vomiting and dehydration can lead to salt or water depletion, which can increase toxicity.[7]

A further article on lithium is scheduled to appear in Update on September 25.

Chronic heart failure

Chronic heart failure is a complex clinical syndrome in which the heart has an impaired ability to respond to physiological demands for increased output. Signs and symptoms include those of underlying heart disorder, such as exertional breathlessness, fatigue and fluid retention.[8]

Prevalence increases with age, to while around 1 per cent of men and women younger than 65 have heart failure, prevalence increases to about 7 per cent for those aged 65 to 84 years, and between 12 to 22 per cent of those aged 85 and over.[9]

Digoxin

Digoxin is indicated in the management of chronic cardiac failure accompanied by atrial fibrillation. The dose has to be tailored individually according to age, lean body weight and renal function.

The difference in bioavailability between injectable and oral presentations must be considered when changing formulations. The dose should be reduced by 33 per cent when switching from oral to IV. Target serum concentrations of digoxin vary between 0.5 nanograms/ml (0.64 nanomol/l) to 1 nanogram/ml (1.28 nanomol/l). Risk of toxicity increases above 2 nanogram/ml (2.56 nanomol/l). Digoxin toxicity can precipitate arrhythmias, which may resemble the arrhythmias for which the drug might be prescribed. Digoxin is a substrate of the P-glycoprotein pump, so inhibitors of P-glycoprotein (eg ciclosporin) may increase blood concentrations of digoxin by enhancing its absorption and/or by reducing its renal clearance.

Onset of effect occurs within two hours and reaches its maximum at six hours when taken orally. The bioavailability of tablets is 63 per cent, while the elixir's is 75 per cent. The initial distribution of digoxin throughout the body generally takes eight hours. This is followed by a gradual decline in serum concentration, dependent on rate of elimination. The volume of distribution is large, indicating extensive tissue binding. Digoxin serum levels, electrolytes and renal function should be assessed periodically depending on the patient's progress.

Digoxin does not affect the outcome of heart failure but does improve exercise tolerance. The benefits to patients are most evident at rest. In patients receiving diuretics and/or an ACE inhibitor, digoxin withdrawal has been shown to result in clinical deterioration.

In patients with subnormal thyroid function, digoxin doses should be reduced, whereas in hyperthyroidism digoxin resistance occurs and the dose may be increased. Patients with malabsorption syndrome or gastrointestinal reconstructions may also require larger doses.

Interactions may arise from effects on renal excretion, tissue binding, plasma protein binding, distribution within the body and sensitivity to digoxin. Serum levels may be increased by amiodarone, indometacin, itraconazole, quinine, spironolactone, antibiotics (trimethoprim, macrolides, tetracycline and possibly others), atorvastatin and carvedilol. Serum levels may be reduced by adrenaline, antacids, colestyramine, acarbose, salbutamol, sulfasalazine, phenytoin, metoclopramide and St John's wort. Verapamil and felodipine increase serum digoxin levels, while nifedipine and diltiazem may increase levels or have no effect.

Hypokalaemia sensitises the myocardium to cardiac glycosides and should be avoided. It is caused by diuretics, lithium salts, corticosteroids, hypoxia, hypomagnesaemia and marked hypercalcaemia.

Common undesirable effects of digoxin can include central nervous system disturbances, dizziness, visual disturbances (blurred or yellow vision), arrhythmia, conduction disturbances, sinus bradycardia, nausea, vomiting and diarrhoea.[10]

Genetic polymorphism

Many of the agents considered suitable for TDM are metabolised through the cytochrome P450 system, so it is important to consider how genetic polymorphism can influence drug serum levels. The majority of the population demonstrates extensive (or normal) metabolism (EM), but a proportion show poor metabolism (PM), which leads to drug accumulation. For some enzymes, eg CYP2D6, a small proportion of the population also demonstrate ultra-extensive metabolism (UM), which leads to reduced drug concentrations at standard doses.[6]

The lowest effective dose for the patient should be used for all TDM drugs.

Looking for alarm signs

With so many preventable deaths, there is scope for pharmacists to use their clinical knowledge and questioning skills to identify any alarm signs. Pharmacists are well placed to analyse blood test results, advise on lifestyle issues, monitor and record progress and refer if they feel a patient needs specialist assessment. Simple questions and measurements provide an in-depth understanding of the patient's progress.

Possible MUR questions include:

- How many seizures/what worsening of symptoms have you had in the last year? This can indicate non-compliance or disease evolution.
- How many medicine doses have you taken this week? This demonstrates compliance.
- How has your mood been since I last saw you? Signs of recent self harm should ring alarm bells.

Regular measurements of the patient's height and weight can be used to calculate their body mass index (BMI). Any changes may impact medicine dose.

Lithium has been the subject of National Patient Safety Agency (NPSA) alerts, and it is strongly advised that pharmacists are aware of the practice recommendations.[11]

Ravina Tasgaonkar MRPharmS is a community pharmacist and part-time lecturer at the University of Portsmouth.

References are available in the full version of this article at www.chemistanddruggist.co.uk/update

Download a CPD log sheet that helps you complete your CPD entry when you successfully complete the 5 Minute Test for this Update article online (p20).

NEXT WEEK
The final part in our series about pregnancy looks at labour and childbirth

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Therapeutic drug monitoring, part 2

Why should people taking phenytoin avoid excessive alcohol? What is the target serum level for lithium? How should digoxin doses be adjusted in thyroid disease?

This article describes why TDM is used for patients taking phenytoin, lithium and digoxin. It includes information about bioavailability, ideal serum levels, side effects and interactions of these drugs.

- Read more about epilepsy management on the Patient UK website at http://tinyurl.com/epilepsy-1.
- Find out more about the TDM of anti-epileptic drugs on the National Society for Epilepsy website at http://tinyurl.com/epilepsy-2.
- Find out more about bipolar disorder from the RCPSYCH website at http://tinyurl.com/d3f83o.
- Update your knowledge of safer lithium therapy from the National Patient Safety Agency website at http://tinyurl.com/y4rpdho. The SOP for supplying lithium includes guidance on supply and useful clinical information.
- Read the MUR tips for bipolar disorder on the C+D website at http://tinyurl.com/37ews3p.
- Find out more about the use of digoxin in heart failure management from the CKS website at http://tinyurl.com/37elbnp.

Are you now familiar with how TDM is used to monitor patients taking phenytoin, lithium or digoxin? Are you confident you could use this information when carrying out MURs?

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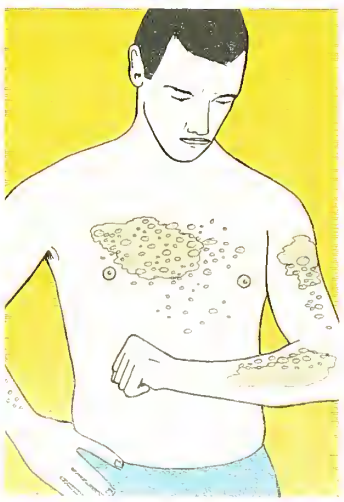
Practical Approach

What's causing the brown skin patches?



At the Update Pharmacy a young man has asked at the cosmetic counter for some camouflage cream and has been referred to pharmacist David Spencer, who sees him in the consultation area.

He says: "I believe you wanted some camouflage cream to cover up patches on your body."

The man replies: "That's right. These brown patches have appeared in the last couple of weeks on my chest and arms and right down to my thighs. I work out in the gym a lot and the exposed areas of my body look quite off-putting. I'm also afraid that it might spoil my chances of attracting girls!"

"Are the patches scaly or just a different colour from your normal skin?"

"Yes, they are a bit scaly. I can actually scrape it off with my finger nail."

"Does it itch or hurt?"

"No, it's completely painless."

"Have you been on holiday anywhere warm recently?" David asks.

"Yes, to Thailand a few weeks back. It wasn't just hot there, it was humid too."

"Well, I think I know what the problem might be," says David. "I can recommend something that should get rid of it, but if it doesn't work you'll have to see your doctor."

1. What is the man's condition likely to be?
2. What treatments, OTC and on prescription, are available?
3. What other condition has a similar presentation?

Answers

1. Pityriasis versicolor, an infection caused by a yeast, Pityrosporum orbiculare. The organism is more common in hot, sunny areas and the incidence has increased in recent years as people have picked up the infection on holiday abroad. Features are: macular (flat) patches of altered pigmentation occurring mainly on the trunk and upper legs and arms; in white-skinned people the patches are brownish and look as if suntanned, while on darker skinned or heavily tanned people the patches are pale or white; the affected area has an overall dappled appearance; there is a superficial scale that can be removed by scraping with a finger nail; pruritus, if any, is mild. Infection often leads to hypopigmentation of the skin, which may persist for months after successful treatment. Infection can be persistent, chronic and difficult to eradicate in some.

2. OTC: an imidazole cream (clotrimazole, miconazole) applied daily for three weeks, or ketoconazole 2 per cent or selenium sulphide shampoo (unlicensed indication), applied to wet skin undiluted and washed off after five minutes, repeated daily for one week, then weekly for several weeks to prevent re-infection. For extensive or persistent infections, options include oral ketoconazole, itraconazole or fluconazole.

3. Vitiligo, a patchy loss of melanin from the epidermis leading to areas of pale skin. The cause is unknown. Patches tend to be much more clearly circumscribed areas of whiteness than in pityriasis versicolor and are especially obvious if the surrounding skin is dark. There is no scaling. There is no totally satisfactory treatment. Make-up and cosmetic camouflage are often the most successful form of management.

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C+D Senate

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The new community pharmacy think-tank

Neighbours from hell or a match made in heaven? The C+D Senate unpicks the pharmacist-GP relationship and identifies how the warring sides can put their differences aside for all patients' benefit. **Zoe Smeaton** reports

The Senators

Graeme Betts
Director of region, Lloydspharmacy
Alastair Buxton
Head of NHS services, PSNC
Michael Cann
Chairman, British Generic Manufacturers Association
Max Gosney
News editor, C+D
Martyn Lobley
GP, south east London
Fin McCaul
Chair, Independent Pharmacy Federation
Gary Pacaggpuri
Editor, C+D
Mitesh Patel
Managing director, Pharma Plus
Adrian Price
Clinical commercial manager, The Co-operative Pharmacy
Steve Roberts
Co-founder, myrepeats web service
Zoe Smeaton
Reporter, C+D
Sue Wood
National director, medicines commissioning, NHS Alliance

TOPIC: **Building better links with GPs**

Problem 1: We're not solving this nationally

Alastair Buxton: "When I was working as a community pharmacist, the relationship we had with the local GP practice was superb and we were a team together. So much of it comes down to those local relationships – you've got to invest in those and that means spending time. One of the great problems with all the work that the pharmacy bodies and the British Medical Association have been trying to do nationally is that we can produce tools but can't nationally make local GPs and local pharmacists talk to each other. LPCs can facilitate that but you've still got to have willing parties on either side."

SOLUTIONS

Hiten Patel: "We need to go back to communication and there needs to be national directions to force the issue of working in partnership with our GP colleagues. The majority of us at a local level get on with our GP practice and our GP colleagues, but we need to take communications to the next level with national requirements for us to work together in certain areas. Otherwise it's all left to goodwill."
Michael Cann: "If we were having this conversation in industry, you would tear up the contracts, say 'These are the three things we want to achieve – clinical excellence, cost effectiveness or whatever goals you come up with', and then you'd all sign up to them and off you'd go. You need very clearly articulated common goals; those need to be signed up to and if there's a need to make them contractual then they need to be contractual."
Hiten Patel: "Perhaps realigning the GP quality and outcomes framework to work in partnership with us would effectively force us to work together?"
Alastair Buxton: "I think that's difficult to achieve because of the challenge of trying to renegotiate two contracts side by side. It also needs political will on both sides of the government and both the professions."

Problem 2: GPs don't understand pharmacists' expertise

Martyn Lobley: "My local pharmacist and I get on like a house on fire but I told a group of colleagues I was coming along to talk to pharmacists today and their view is that doctors write prescriptions, pharmacists take the boxes off the shelves and they can't see what all the fuss is about. When you get to things like MURs, their eyes glaze over and they either get exasperated or they walk off."

SOLUTIONS

Adrian Price: "I think it's about us explaining what we've got to offer and I still don't think we articulate that very well. PCTs and doctors might not understand pharmacy and to some extent we've got to take it upon ourselves to make them understand."
Martyn Lobley: "Pharmacists spend so much time in their training learning about pharmacology

"We shouldn't be stuck on the high street, I think we need to be in those health centres"
DAVE ROBERTS
CO-FOUNDER, MYREPEATS

and pharmacokinetics and none of that gets back to GPs. Most GPs have no idea about those things. Put that knowledge into practice and start ringing people up. We write a publication called Prescribing Matters for the PCT and the pharmacist does most of the work – we pay him for doing it. We also pay him a bonus if we hit our prescribing incentives."

Dave Roberts: "My pharmacy is situated in a GP surgery so we do a lot of work for the GPs with regard to chronic disease management and minor ailments, and reviewing prescribing on a regular basis. The integration has been marvellous and I think it's where pharmacies should be – we shouldn't be stuck on the high street, I think we need to be in those health centres, and integrated, not just co-located."

Problem 3: Communication links are breaking down

Hiten Patel: "We've gone backwards a step because PCT professional executive committees (PECs) were an excellent model for communication. Where pharmacists were on PECs it was an excellent way to meet up with GP colleagues. But PECs were mostly dissolved and that communication link broken, and now we have commissioning groups where we haven't really been invited to the table and we have been out of the loop for quite a while."

SOLUTIONS

Alastair Buxton: "It's probably for pharmacy to initiate the discussions where they're not happening because we've got more to gain. We need to initiate them and we need peer support where people are concerned about talking to their GP."

Graeme Betts: "I agree sometimes pharmacists and branch managers don't have the confidence to go and talk to GPs. We try to give them the relationship skills and communication tools to do that."

Problem 4: The professions are fighting over the same money

Alastair Buxton: "GPs and PCTs will fall out sometimes at a local level because of the cash and where the PCTs spend that."

Julie Wood: "You're right that the issues are around commissioning – if you are both trying to dabble in the same pool for the same resource that's where some of the tensions can come in."

SOLUTION

Julie Wood: "You need to think about making the commissioning clusters or whatever they become aware of what the added contribution and value of an enhanced community pharmacy service can be because some GPs won't know that. Not all PCTs have got fully behind things like practice-based commissioning and because they don't have to have a pharmacist around it has been seen by some as an optional extra.

"PCTs need to get the message that they must grab hold of the big issues and that with pharmacists also in the decision-making process then they can redesign services in a way that we haven't yet thought of."

Problem 5: Pharmacists are still seen as shopkeepers and not as clinicians

Martyn Lobley: "It's funny how patients often say pharmacists have 'given' them something. Pharmacists don't give things away, they've sold them something. Many GPs still think of pharmacists as shopkeepers and that a lot of what pharmacists sell over the counter is either useless or inappropriate. The running joke is that when doctors find out that something doesn't work we let pharmacists sell it in half doses."

SOLUTIONS

Graeme Betts: "The problem is the funding system – at the end of the day we're supplementing a declining NHS income with other things."

Adrian Price: "I'd counter that because there are a lot of evidence based medicines available over the counter now as well."

Michael Cann: "You also can't forget that it is government policy to move medicines from POM to P and there are very useful healthcare OTC categories."

Martyn Lobley: "But you've got to stop selling placebos and pretending that they are medicines."

Senators' top tips for building links with your GP

"I'd urge people not to stray outside their bounds of expertise. We don't expect pharmacists to be diagnosticians so please don't pretend to be, and don't expect us to be pharmacology experts because we aren't. Let's hear from you what you can teach us and we'll tell you what we can teach you."
Martyn Lobley, GP, south east London

"We're quite innovative as a sector but we're not given the opportunity to take that forward and best practice is not shared everywhere and that's a problem."
Hiten Patel, managing director, Pharma Plus

"Find your local movers and shakers in terms of commissioning, look for the win-win and work with them to develop a cast iron commissioning case, because unless you win the commissioning argument there will be no opportunities to win the provision argument."
Julie Wood, national director clinical commissioning, NHS Alliance

"For individual pharmacists trying to develop a relationship with an individual GP practice, I'd suggest finding a little project to work on collaboratively on a clinical issue involving shared ownership. Use that to develop relationships and then build on those."
Alastair Buxton, head of NHS services, PSNC

The Senate Ruling

1. **Communication needs to be facilitated both at a local and a national level.**
2. **Pharmacists need to make the first move and ensure GPs understand their expertise and what they can offer.**
3. **GPs' and community pharmacists' financial contracts need to be aligned.**

CPD Reflect • Plan • Act • Evaluate

Tips for your CPD entry on building links

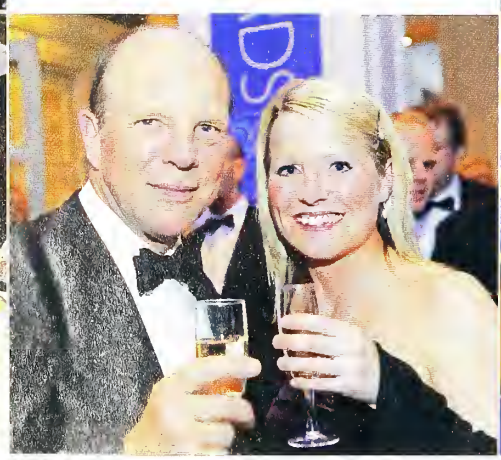
REFLECT	Do I work well with local GPs?
PLAN	Consider how I can work more in collaboration with local GPs
ACT	Implement a joint working project on a specific clinical issue
EVALUATE	Has my relationship with local GPs improved?

C+D Awards 2010

The 14 winners of the third C+D Awards, in association with the NPA, were announced in style last week. Take a look at what happened on the night

Glitz, glamour and community pharmacy collided in London's Mayfair last week, at the C+D Awards 2010. A who's who of the sector joined the 69 shortlisted candidates and their colleagues, family and friends to find out who had won the 14 coveted trophies and celebrate the very best community pharmacy has to offer. And after the much awaited announcements, compèred by TV personality Giles Brandreth, the celebrations continued into the small hours, helped along by the Grosvenor House Hotel's good food, flowing wine and a play-money casino.

(Clockwise from above) The big names in pharmacy, including contractor Graham Phillips, Professor Nick Barber and the NPA's Nicola Rossi, watched as C+D editor Gary Paragpuri and NPA chairman Ian Facer introduced the C+D Awards 2010. Winners included Community Pharmacist of the Year Taseen Iqbal, presented with his trophy by sponsor Teva's Kim Innes. Guests, including sponsor McNeil's David Mitchell, Lloydspharmacy's Andy Murdock, NPA vice-chairman Bharat Patel and GPhC chairman Bob Nicholls, watched as the 14 winners were welcomed to the stage by violinist Sarah Tuke



Oh, what a night: The 14 triumphant winners of the third annual C+D Awards included Team of the Year Fishers Chemist (top right), Pre-registration Graduate of the Year Sharon Lindsay (bottom centre), MUR Champion of the Year Samiah Tambra (middle left) and Pharmacist Prescriber of the Year Colin Dougall (top left). Guests – including England's chief pharmacist Keith Ridge and Boots' Paul Bennett (bottom left), Actavis managing director Sara Vincent, Community Pharmacy Scotland CEO Harry McQuillan and NPA chairman Ian Facer (second right with Dr Ridge), CCA chairman Rob Darracott, PSNC chief executive Sue Sharpe, RPSGB director for England Howard Duff and IPF chairman Fin McCaul (fourth right) – enjoyed a champagne reception, three-course dinner and a play-money casino (bottom right and top) as the celebrations continued into the small hours

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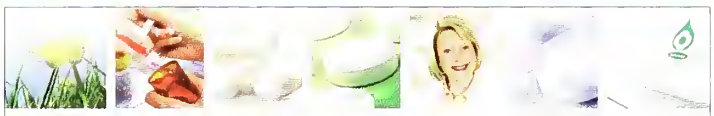

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Secrets spilled at C+D Awards

Postscript had a ball at last week's C+D Awards (pictured above), when it ran into quite a few well-known faces in the pharmacy world – and found out some little-known facts about them.

Did you know, for example, that environment-conscious PSNC chief executive Sue Sharpe drives a hybrid Toyota Prius? That Lloydspharmacy pharmacy director Andy Murdock is a qualified pilot? Or that Reckitt Benckiser sales development controller Trevor Gore has appeared (and won) on daytime quiz shows?

The cricket connection was strong at the Awards, too. Not only was Actavis commercial director (and former professional cricketer) Michael Cann present, but last year's pre-registration pharmacist of the year Gursharan Rattan revealed she recently got married to none other than England spin sensation Monty Panesar. Congratulations to the happy couple.

Perhaps the most surprising revelation was that of former NPA chief John Turk. After leaving the trade body, Mr Turk decided to indulge his inner Hells Angel, and took off around Australia on a Harley-Davidson motorbike. In case you don't believe us, take a look at the photos on page 10.

Who says pharmacy is dull?

A social tweet

From pharmacy in-jokes to boozing, join the debate at www.twitter.com/chemistdruggist

@CandDChris: OK, hands up who knew Hannibal Lecter makes a pharmacy joke in Silence of the Lambs? Anybody? Can't believe I didn't spot it.

@CandDChris: "I ate his liver with some fava beans and a nice chianti" – Lecter is listing three foods you can't eat if you're on MAOI antidepressants.

@CandDJennifer: Any community pharmacists out there been involved in alcohol screening/advice/intervention services? I'd like to hear about it.

@PillmanUK: @CandDJennifer I think there were [illegible]s of pharmacists involved with alcohol last [illegible]at the C+D awards!

Spot the mug

Calling all beady-eyed C+D readers! It's time for another competition. Postscript sent its spies to get hold of the photos for last week's C+D Awards, and sneakily hid a C+D mug in one of the snaps. If you fancy winning this stylish, limited edition prize (pictured), turn back to pages 24 and 25, spot where we've stashed it, and email your answer to postscript@chemistanddruggist.co.uk. A winner will be chosen from all correct answers we get before 12pm on June 25.

And no, despite a number of requests with previous entries, you can't have Postscript's pirate pencil sharpener instead.

Last week's top stories on C+D's website

1. Lloydspharmacy rapped by MHRA over advertising rules breach
2. AAH MD Mark James calls on pharmacy minister to come clean on cuts
3. Update Module 1529: Interpreting blood test results (pt 1)

The Victorian Pharmacist

"THE PRISONER STATED HE TOOK THE MONEY, BUT NOT WITH ANY FELONIOUS INTENT"

Sir,

I was recently challenged by a colleague to solve the riddle of a troublesome apprentice, who was robbing the till to a considerable extent. My colleague asked me what proof would be necessary to cancel his indenture, and would it require police involvement?

My answer was as follows. The first step towards a legal right to have the indenture cancelled would be prosecution for robbery. It is a leading principle of English law that every person is assumed innocent until his guilt is proved, and that there is no recognised mode of proving guilt except conviction by a court.

Private arrangements are objectionable, because of the encouragement thereby given to the offender and others to persist in their vicious career. However, if my colleague felt such an arrangement desirable, I did not apprehend any difficulty in carrying it to effect. If the father of the apprentice be a respectable man, he would gladly consent to the indenture being cancelled rather than have his son prosecuted, and would doubtless make good any losses sustained.

It is worth marking that on May 17 of this year Athol Dawson was charged with stealing two shillings and one florin from his employer, Stephen Wand, chemist. The prisoner stated that he took the money out of the till, but not with any felonious intent. He wanted to meet some heavy expenses, and would have paid it back when he drew his monthly wages. The bench sentenced the prisoner to two months' hard labour.

While this sentence is no doubt extremely lenient, it serves as a hearty reminder to all apprentices: pilfering shall not be tolerated.

The Victorian Pharmacist's comments come from two articles published by C+D in 1883, when employees could find themselves breaking rocks for stealing what now amounts to about £2.25. Have you had to deal with employee theft? What did you do? Let the Victorian Pharmacist know: postscript@chemistanddruggist.co.uk

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Boehringer Ingelheim **Flomax Relief® MR – Product Information. Presentation:** Flomax Relief MR containing 0.4mg of tamsulosin hydrochloride in a modified release capsule. **Indication:** Treatment of functional symptoms of benign prostatic hyperplasia (BPH). **Dosage:** For men aged 45-75 years. For oral use. One capsule daily. **Contraindications:** Hypersensitivity to any ingredients of the product, a history of orthostatic hypotension, severe hepatic insufficiency. **Warnings and Precautions:** Men taking an antihypertensive alpha$_1$-adrenoceptor blocker should consult a doctor before taking Flomax Relief. In individual cases a fall in blood pressure can occur. Do not give to a man who experiences postural hypotension. Consult a doctor before taking Flomax Relief if a man has heart, renal, or liver disease, uncontrolled diabetes, urinary incontinence, or has had prostate surgery. Do not supply Flomax Relief to a man whose symptoms are of less than 3 months' duration. Do not supply to a man who reports dysuria, haematuria, or cloudy urine, in the previous 3 months, or who has a fever that might be related to urinary tract infection. Do not initiate treatment in a man planning cataract surgery, or who has recently experienced blurred or cloudy vision not examined by a doctor or optician. If urinary symptoms have not improved within 14 days of starting treatment the patient should be referred to a doctor. Medical review is required for diagnosis of BPH: Patients must see their doctor within 6 weeks of starting treatment for assessment of their symptoms and confirmation to continue taking Flomax Relief long-term from their pharmacist. Every 12 months, patients should be advised to consult a doctor. **Adverse Effects:** *Common*: dizziness. *Uncommon*: headache, palpitations, postural hypotension, rhinitis, constipation, diarrhoea, nausea, vomiting, rash, pruritus, urticaria, abnormal ejaculation, asthenia. *Rare*: syncope, angioedema. *Very rare*: priapism. Drowsiness, blurred vision, dry mouth or oedema can occur. IFIS has occurred in some patients during cataract surgery. **RRP (ex VAT):** 14 capsules £7.65, 28 capsules £14.46 **Legal Category:** P **Product Licence Number:** PL 00015/0280. **Date of revision:** December 2009. **Further information available from:** Boehringer Ingelheim Limited, Consumer Healthcare, Ellesfield Avenue, Bracknell, Berkshire RG12 8YS. **References** 1. Narayan P et al. Journal of Urology 1998;160:1701-1706. 2. Flomax Relief MR Summary of Product Characteristics. 3. Simpson RJ et al. British Journal of General Practice 1994;44:499-502. **Date of preparation:** December 2009/FMX0133

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